



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

WORKER'S COMPENSATION

Effective Date: May 14, 2015

Policy #: SF-07

Page 1 of 4

I. PURPOSE:

- A. To identify responsibilities in the event of a work related injury that results in Worker's Compensation benefits.
- B. To establish a process for employees injured at work to return to work in a limited capacity.

II. POLICY:

- A. It is the intent of Montana State Hospital (MSH) to work with injured employees, their health care provider, and Montana State Fund to maintain an Early Return To Work (ERTW) program to allow injured employees to return to work in a transitional capacity where activities are temporarily limited according to medical necessity.

III. DEFINITIONS:

- A. Early Return To Work - A program that involves the employer, the injured employee, the employee's health-care provider, and Montana State Fund working together to identify transitional assignments that allow an injured employee to return to work in a capacity that does not interfere with physical restrictions (as identified by their health-care provider).
- B. Transitional Assignment - A temporary work assignment that includes duties that do not interfere with an injured employee's physical restrictions (as identified by their health-care provider).
- C. Time of Injury Job Analysis (JA) - An assessment of an employee's regular duties to provide a physician with an accurate description of the physical demands of the employee's regular job so the physician can provide medical approval or disapproval for an employee to perform that job.
- D. Modified Job Analysis (JA) - An assessment of modified duties to provide a physician with an accurate description of the physical demands of a modified position so the physician can provide medical approval or disapproval for an employee to perform that job.

IV. RESPONSIBILITIES:

- A. Safety Officer - Work with injured employees, supervisors, and Montana State Fund to ensure prompt claims reporting and managing from time of injury to time of closure of the claim.
- B. Employees - Report injuries to their immediate supervisor at the time of the injury. To make regular contact (at least every three weeks) with their supervisor and the Safety Officer when they are away from work as the result of a work related injury. To provide a Medical Status Form statement to their supervisor and the Safety Officer after each work related physician visit. MSH's Medical Status Form (Attachment A) should be completed by the employee's physician at each doctor appointment. Employees must make contact with their supervisor and the Safety Officer at least every three weeks.
- C. Supervisors - Report all injuries to the Safety Officer. Work with the Safety Officer and Montana State Fund to identify transitional duties for an employee returning to Early Return To Work (ERTW) status. Coordinate with the Safety Officer to ensure the injured employee is:
 - 1. Making regular contact (at least every three weeks) with the Supervisor and Safety Officer.
 - 2. Providing medical documentation after each physician visit.

V. PROCEDURE:

WORKER'S COMPENSATION

- A. Injured employees must complete an Incident Report anytime they are injured. The employee must give the completed Incident Report to their immediate supervisor at the time of the injury whenever possible. **The supervisor must be given the Incident Report before the end of the employee's shift if feasible, but not longer than 6 days.**
- B. Employees must notify their immediate supervisor and the Safety Officer if they miss work as the result of an injury that occurs at work.
- C. Employees must notify their immediate supervisor and the Safety Officer if they seek medical attention as the result of an injury that occurs at work. Employees must obtain a Medical Status Form from their physician anytime they see a physician as the result of an injury that occurs at work.
- D. The Safety Officer must complete a "First Report" for all employees who miss work or seek medical attention as the result of an injury that occurs at work. The "First

Report" must be submitted to Montana State Fund within six (6) days of the notification of the Safety Officer.

EARLY RETURN TO WORK (ERTW)

- A. The Safety Officer will coordinate with the injured employee's supervisor to identify transitional assignments that may be available in the work area.
- B. The Safety Officer will work with Montana State Fund to develop a Modified Job Analysis for the transitional assignment.
- C. The injured employee's health care provider must review the Modified Job Analysis to ensure the duties are within the injured employee's physical abilities. The health care provider should sign MSH's Medical Status Form indicating if the employee is physically able to perform the duties identified in the JA. The employee must submit Medical Status Form to their supervisor immediately after their medical appointment. A copy must be sent to the Safety Officer for placement in the injured employee's worker's compensation folder.
- D. If the employee is released to work a transitional assignment, the supervisor must focus on modifying the employee's existing job when possible. At all times the supervisor must ensure the employee does not engage in any activity that is beyond the employee's physical limitations.
- E. At the end of three weeks, the transitional assignment will be reviewed to determine how the employee is progressing and to decide if adjustments need to be made in the transitional assignment.
- F. Transitional assignments may be extended up to 180 days if the injured employee continues to show improvement each week and submits verification from their healthcare provider no less than every 30 days indicating continuing improvement. **Upon an initial 90 transitional duty assignment, a review will be completed with the Workers Compensation Claims Adjuster and the Health Care Provider to determine whether another period of transitional duty is appropriate.**
- G. Employees working in a transitional assignment must be aware of and must not exceed physical limitations identified by their personal physician. Exceeding physical limitations may result in disciplinary action.
- H. Employees working in a transitional assignment must complete a Leave of Absence Request Form for any time missed due to their injury. In addition, employees must abide by all policies and procedures relating to missed work.
- I. Transitional assignments may be on an alternate shift or work area.

Montana State Hospital Policy and Procedure

WORKER'S COMPENSATION

Page 4 of 4

J. Employees working in a transitional assignment are not eligible for overtime assignments.

VI. REFERENCES: DPHHS Worker’s Compensation Policy; MSH Policy #SF-04, “Incident Response And Reporting.”

VII. COLLABORATED WITH: Hospital Administrator, Director of Nursing, Director of Quality Improvement & Public Relations, Director of Human Resources.

VIII. RESCISSIONS: #SF-07, *Worker's Compensation* dated December 9, 2011; # SF-07, *Worker's Compensation* dated May 18, 2010; # SF-07, *Worker's Compensation* dated May 12, 2003; # SF-07, *Worker's Compensation* dated May 12, 2003.

IX. DISTRIBUTION: All hospital policy manuals

X. REVIEW AND REISSUE DATE: May 2018

XI. FOLLOW-UP RESPONSIBILITY: Safety Officer

XII. ATTACHMENTS:

A. Medical Status Form

_____/_____/_____
John W. Glueckert Date
Hospital Administrator

_____/_____/_____
 Todd Thun Date
 Director of Human Resource

MEDICAL STATUS FORM

Employer Contact Information (Optional) Montana State Hospital
P.O. Box 300, Warm Springs MT 59756
406-693-7207 FAX 693-7257
ATTN: Safety Officer

Employee Info	Employee's Name (Last, First) _____	Date of Birth (mm/dd/yyyy) _____	Provider Timestamp _____
	Claim Number _____	Date of Injury (mm/dd/yyyy) _____	Provider Contact Information _____

Released for Work?	<input type="checkbox"/> Employee Released to Full Duty	Date _____	To _____
	<input type="checkbox"/> Employee Released to Modified Duty (See Work Abilities)	Date _____	To _____
	<input type="checkbox"/> Employee May Work Limited Hours: _____ hours per day	Date _____	To _____
	<input type="checkbox"/> Employee May Work Part-time: _____	Date _____	To _____
	<input type="checkbox"/> Employee Not Released to Work	Date _____	To _____
	<input type="checkbox"/> Capacity Duration (estimate days): <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> 30+ <input type="checkbox"/> permanent		

Modified Work Abilities	Blank Space = Not Restricted (NR)	Continuous	Frequent	Occasional	Never	
	Hand/Wrist <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Grasping <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Pushing/Pulling <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Fine Manipulation <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Reaching <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Lifting 01-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Lifting 11-20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Lifting 21-25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Lifting 26-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Lifting 51-70 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Number of Hours Employee May: Sit _____ Stand _____ Walk _____					
	List Other Restrictions:					

Signatures	Employee Signature _____	Date _____
	Provider Signature _____	Date _____

☐ Copy of Medical Status Form to employee Date of Next Visit _____

Treatment Plan	Employee Progress: <input type="checkbox"/> As expected/better than expected <input type="checkbox"/> Slower than expected	<input type="checkbox"/> Treatment Concluded by provider: _____
	Current Rehab: <input type="checkbox"/> PT OT Home Exercise <input type="checkbox"/> Other: _____	<input type="checkbox"/> Max. Medical Improvement (MMI): _____
	Surgery: <input type="checkbox"/> Not Indicated <input type="checkbox"/> Possible <input type="checkbox"/> Planned	Care Transferred to: _____
	Comments: _____	Consultation needed with: _____
		Study Pending: _____
		Medications: _____
		Opioids prescribed for: <input type="checkbox"/> Acute Pain <input type="checkbox"/> Chronic Pain
		Diagnosis: _____